



# ***Financing Aged Care***


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## Australia's aged care system

- **Australia has an extensive aged care system, covering residential and domiciliary care.**
  - The system provides residential care for some 160 000 people each night.
    - Residential care accounts for 80% of formal aged care spending.
- **By and large, the system achieves reasonably good levels of equity, in terms of access, and of quality. However, it performs less well in terms of efficiency and sustainability.**
- **The system is largely funded by the Commonwealth Government which has primary funding responsibility for funding residential care and shares funding responsibility for community care with the States.**
  - The Commonwealth Government pays:
    - half the costs of residential accommodation for people requiring low levels of care, and
    - the majority of costs for people requiring high levels of care, whether residential or domiciliary

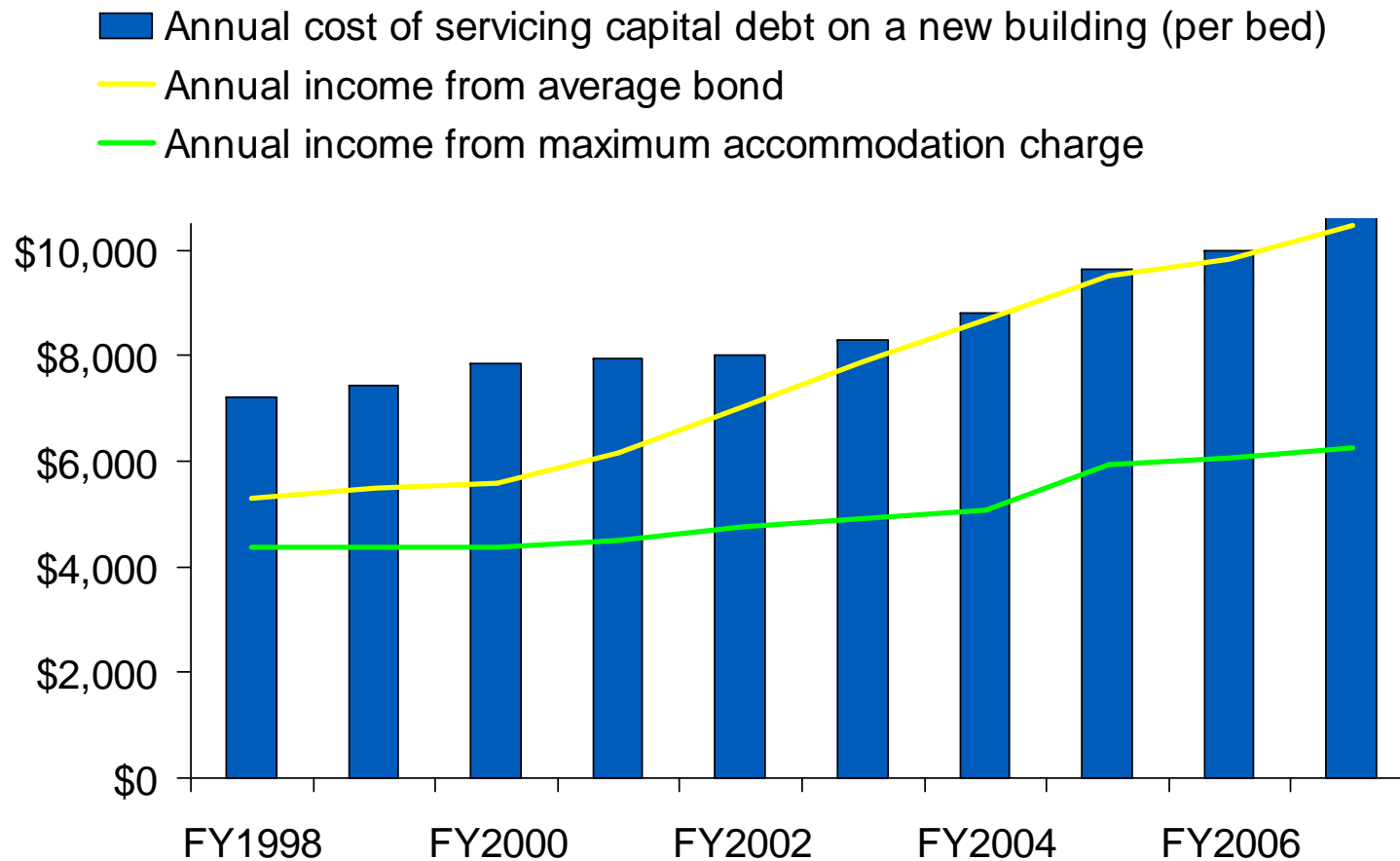
- **The disability-adjusted, capitated, nature of payments made to care providers is arguably well-suited to the chronic character of the conditions being treated.**
  - Although capitation creates incentives to skimp on quality which need to be addressed with quality of service regulation.
- **However, population aging will strain the system.**
  - To meet the 2007 ratio of 88 places per 1000 aged persons in 2025, there would need to be an increase of 83,100 low care and 87,400 high care places, an approximate doubling in the number of places.
  - However, even doubling the current number of places will be insufficient.
  - Moreover, a change in the structure of supply is needed, with an increase in the number of domiciliary care and residential high care places relative to residential low care.
  - Additionally, the supply structure needs to cope with an increasingly bi-modal distribution of care durations, as:
    - Longer care durations are experienced in both domiciliary care and high care, in part thanks to increased incidence of severe chronic conditions; and
    - There is an increased demand for relatively short duration respite care.

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- **In an ideal world, the role of public policy would be limited to establishing a framework where market forces could provide individuals with care choices that matched their needs, while also providing an effective safety net for those with little ability to pay.**
  - **Such a framework would likely involve a relatively high degree of service quality regulation, given:**
    - (a) the frail condition of many beneficiaries; and
    - (b) the difficulties involved in relying on market forces alone to regulate service quality in an activity where consumers are poorly placed to voice their concerns or switch service provider.

- **So as to manage its fiscal risk, the Commonwealth extensively regulates care provision beyond what is required to ensure service quality.**
  - Planning ratios are used to control the number, composition and location of care places made available.
  - There are also extensive price controls, as well as means test that are used to determine the extent of the subsidies provided.
- **Rationing of places allows management of fiscal risk, but also creates an artificial scarcity that deprives consumers of choice, limits scope for competition and blunts pressures for efficiency and innovation.**
  - Since 2000, occupancy levels in residential care facilities have generally been in excess of 90 per cent for low care and of 95 per cent for high care.
  - This means that there are often very few places open in any particular locality. In 2005-2006, for example, there were (on average) fewer than 3 vacant places each day for every 1000 people aged 70 or over in a third of the 71 aged care planning regions.

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- **Constraints on competition mean that pressures for technical efficiency in the sector are relatively weak, all the more so given the role of non-profit providers, with the result that there is a large and persistent gap between unit costs of the most cost-efficient and least cost-efficient suppliers.**
  - **At the same time, because choice is restricted, some form of price control is needed to prevent abuse of localised market power:**
    - Controls on prices for ‘low care’ residential care are not especially effective – bonds are effectively uncapped and allow a significant income stream into low care
    - In contrast, there are important long term issues about the incentives to invest in high care

## It is primarily bonds that have supported revenue growth



## However, this creates issues for high care

- **With some 30 per cent of current non-concessional “high care” residents having paid “low care” bonds, there has been a cross-subsidy, or at least a financial transfer, from “low care” to “high care”, mitigating the impacts of the price controls**
  - In 2005-06, only one third of aged care homes that catered predominantly for residents needing high level care (ie, fewer than 20 per cent of residents receiving low level care) did not hold any accommodation bonds.
- **Put slightly differently, the financing of high care places depends on the flow of admissions into low care. However, demographic trends suggest demand for low care places will decline in future, at least in relative terms:**
  - Growing use of community care will contribute to this trend
- **This means we can expect a decline in a key source of funding for high care places just as the need for such places increases.**


## Financing and demand

- **Issues associated with financing are rendered more complex by likely strong growth in demand for domiciliary care, especially as the baby boomers enter the aged care population.**
- **The resulting tensions will place ever greater political pressures on governments to increase subsidies to domiciliary care.**
- **However, domiciliary care is inherently expensive, especially for conditions that require multiple interventions and the trend to rising costs will be accentuated by:**
  - A reduction in the supply of voluntary carers,
  - Strong competition for health professionals from other parts of the health system, and
  - Rising travel costs.
- **Moreover, domiciliary care is especially vulnerable to moral hazard, imposing substantial fiscal risks on governments.**

## The combination of pressures on high care and of growing demand for domiciliary care creates obvious questions about how expansion will be financed

- **As regards the Commonwealth, the burden on taxpayers and the Commonwealth budget associated with the existing arrangements seems likely to increase sharply over time.**
  - Aged care funding currently consumes about 3% of Commonwealth revenues.
  - By 2046-47 it is projected to grow (under current policy setting) to about 9%, assuming Commonwealth revenues remain at their long term average of about 22% of GDP.
- **Fiscal constraints will lead to pressures to shift more of the financial burden to care recipients. In fact, effective co-payment rates have been increasing for some time.**
  - Payments by entrants to low level residential care increased from 40 percent of total care costs in 1995-96 to 57 per cent in 2005-06.
  - Payments by entrants to high level residential care paid increased from 21 per cent of care costs in 1995-96 to 29 per cent in 2005-06.
  - At the same time, co-payment schedules have been becoming more progressive.

- **A progressive co-payment system may not be inefficient:**
  - It can help address issues of moral hazard (especially in domiciliary care)
  - There is practically no labour/leisure substitution among the very elderly, and co-payments have a muted effect on life-time labour/leisure decisions. As a result, a reasonably progressive co-payment structure may be consistent with optimal taxation.
- **However, a progressive system of co-payments may induce inefficient behaviour.**
  - For example, the running down of assets and income, and investment in ways of evading the means test.
  - Moreover, it may create anomalies and in some instances, hardship.
- **Moreover, increasing the co-payment rate increases the income risk facing the elderly population:**
  - The risk of requiring aged care is closely associated with longevity risk.
  - The lifetime risk of requiring permanent residential aged care in Australia rises from around 35 per cent at birth to over 60 per cent at age 90.
  - But while the risk of requiring aged care rises with age, the variance of stay durations and hence of costs remains high, and indeed, appears to be increasing materially, meaning that cost exposure is highly variable.
  - Experience internationally suggests it is difficult for voluntary insurance markets to cover this risk.

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- As a result, the Commonwealth is likely to remain best placed to manage this risk.
  - However, even in that scenario, the regulatory system needs to be restructured
    - There should be moves away from controls on place numbers towards a system that provides a vouchers that can be used in a competitive environment
    - Current entitlements – especially supplementary payments for residents with few or no assets – could be reformed to more effectively secure equitable outcomes.
    - Overall, the system should provide more of a topping-up payment for aged care services, and exercise fewer controls over prices and entry.
  - Although practical difficulties mean reform of the entire system is likely to be protracted, demographic pressures require greater attention on such reform, instead of merely tinkering with the current system.



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